

Why Professionalism Matters: Lessons from the Ashes



Robert Sumwalt

The one take-away

Insist on
**PROFESSIONALISM
AND INTEGRITY**
in your operation.

“The pilots’ failure ... was symptomatic of poor airmanship and a broader pattern of deficiencies in their CRM skills (specifically in the areas of leadership, workload management, communications/briefings, and crew coordination) ...”





“the pilots’ unprofessional behavior, deviation from SOPs, and poor airmanship, which resulted in an in-flight emergency from which they were unable to recover.”

“The flight crewmembers’ performance during the flight, including the captain’s deviations from SOPs and the first officer’s failure to challenge these deviations, was not consistent with the CRM training that they had received ...”







American Airlines flight 1400

“I’m ambivalent right now. I got six months to go.”

- Captain of AA 1400

In-Flight Left Engine Fire
American Airlines Flight 1400
McDonnell Douglas DC-9-82, N454AA
St. Louis, Missouri
September 28, 2007



Accident Report
NTSB/AAR-09/03
PB2009-910403



National
Transportation
Safety Board

“The casual atmosphere in the cockpit before takeoff affected and set a precedent for the pilots’ responses to the situations..., eroded the margins of safety provided by the standard operating procedures and checklists, and increased the risk to passengers and crew.”



NTSB

PSA AIRLINES (D.B.A. US Airways Express) January 2010





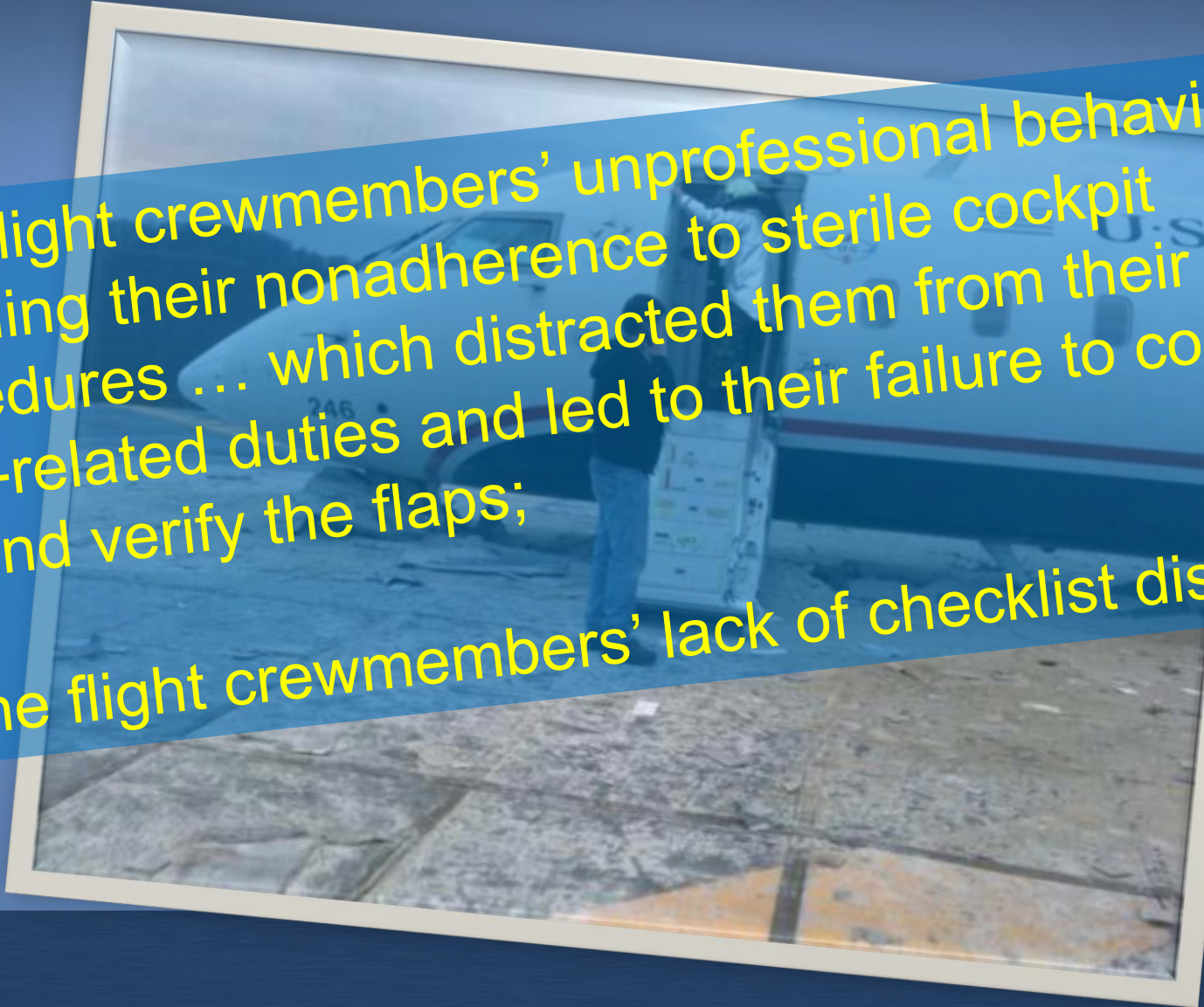
Who	Statement / <i>editorial comment</i>
F/O	oh we talked about you know we want fifteen acres.
Capt.	[expletive].
F/O	the house'll sit kind of in one of the front corners but back up off the road where it can't be seen.
Capt.	yeah...that's— yeah.
F/O	and we— she wants a road track built on the property.
Capt.	aww man that'd be cool as [expletive].



Approximate location
of stopped aircraft.

Lack of Professionalism

“The flight crewmembers’ unprofessional behavior, including their nonadherence to sterile cockpit procedures ... which distracted them from their primary flight-related duties and led to their failure to correctly set and verify the flaps;
... the flight crewmembers’ lack of checklist discipline.”

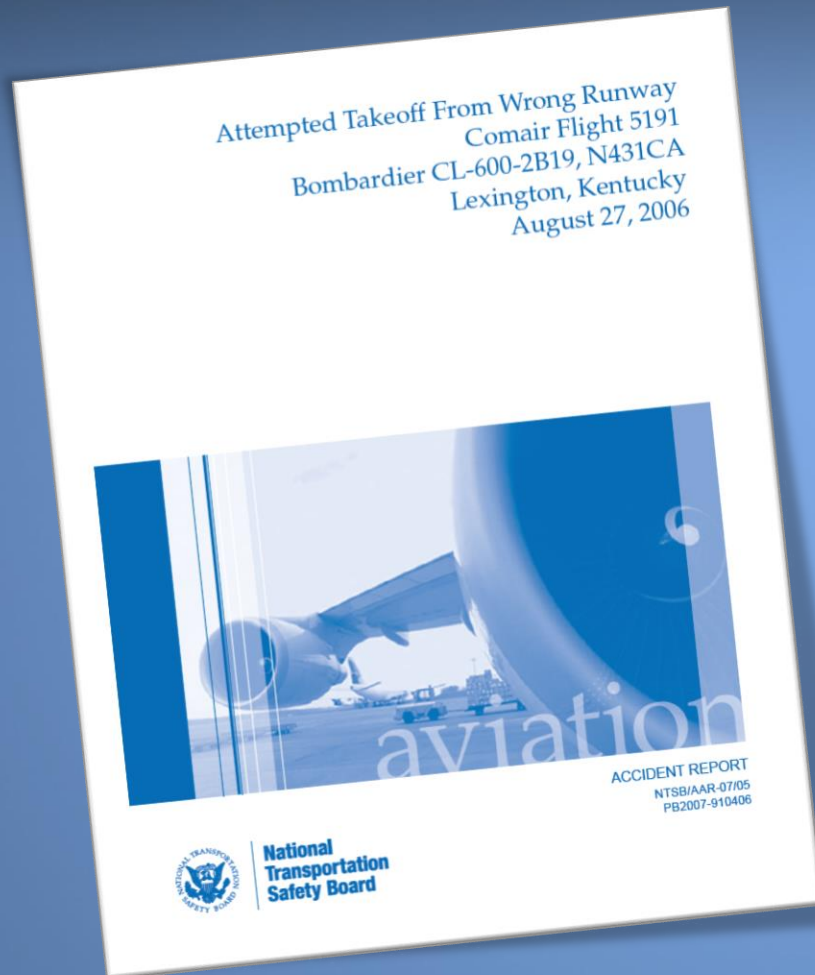


Comair 5191



Time	Who	Statement / <i>editorial comment</i>
05:52:11	Capt.	"I'm easy buddy."
05:56:14	Capt.	"run the checklist at your leisure."
05:57:36	Capt.	"Before starting, at your leisure."
05:58:12	Capt.	"Start engines, your leisure."
05:59:42	Capt.	"he said it's okay to turn one at your leisure."
05:59:45 to 06:01:47		<i>Crew engages in two minutes of non-pertinent conversation during engine start</i>
06:03:12	Capt.	"finish it up, your leisure."
06:03:16		<i>First officer initiates and captain participates in, 40 seconds of nonpertinent conversation.</i>
06:05:15	F/O	"churlieser [<i>'at your leisure' spoken very fast</i>], Comair one twenty one ready to go."

NTSB Finding



“The flight crew’s noncompliance with standard operating procedures... and both pilots’ nonpertinent conversation, most likely created an atmosphere in the cockpit that enabled the crew’s errors.”

Bedford, MA

May 2014





NTSB Investigation Found

- The flight crew failed to disengage the gust lock.
- None of the five manufacturer specified-checklists were verbalized on the accident flight.
- No complete flight control check for 173 of the past 175 flights.



Probable Cause

- The NTSB determines that the probable cause of this accident was the flight crewmembers' failure to perform the flight control check before takeoff...
- Contributing to the accident were the flight crew's habitual noncompliance with checklists ...

DEDICATED TO HELPING BUSINESS ACHIEVE ITS HIGHEST GOALS.



“As perplexing as it is that a highly experienced crew could attempt a takeoff with the gust lock engaged, it is equally disturbing that the data highlights a lack of professional discipline among some crews in not accomplishing manufacturer-directed checklists – particularly safety-of-flight critical items.”

NBAA REPORT Business Aviation Compliance With Manufacturer-Required Operational Quality Assurance Routine Flight Control Checks Before Takeoff

In its final report on the May 31, 2014, Gulfstream G650 accident at Laurence G. Hanscom Field in Bedford, MA, the NTSB recommended that NBAA work with existing business aviation flight operational quality assurance groups to analyze the extent to which noncompliance with manufacturer-required routine flight control checks before takeoff exists. This NBAA report provides the results of this analysis to members.



NTSB

DEDICATED TO HELPING BUSINESS ACHIEVE ITS HIGHEST GOALS.



“... complacency and lack of procedural discipline have
no place in our profession.”

NBAA REPORT

Business Aviation Compliance With Manufacturer-Required
Flight-Control Checks Before Takeoff

In its final report on the May 31, 2014, Gulfstream G-IV accident at Laurence G. Hanscom Field in Bedford, MA, the NTSB recommended that NBAA work with existing business aviation flight operational quality assurance groups to analyze the extent to which noncompliance with manufacturer-required routine flight-control checks before takeoff exists. This NBAA report provides the results of this analysis to members.



NTSB

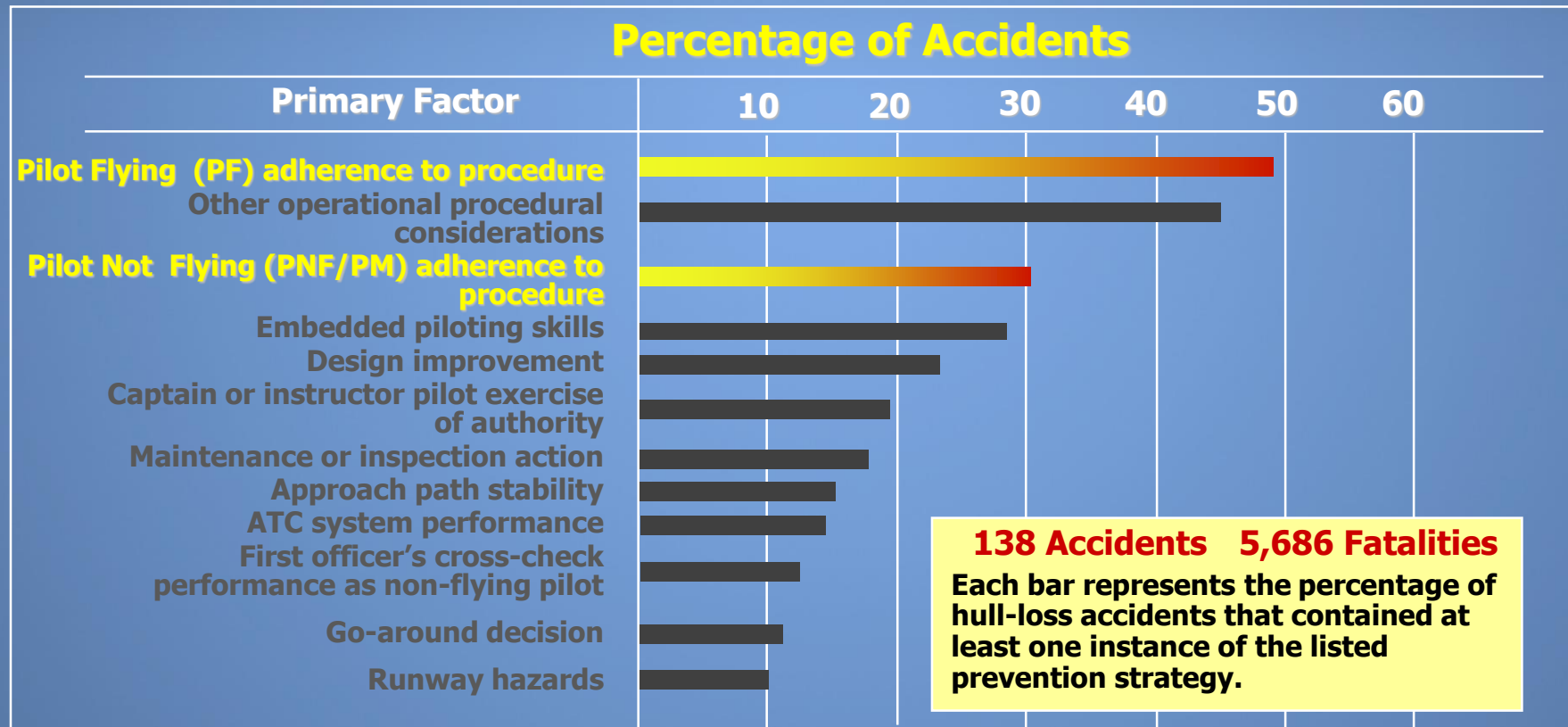
Intentional non-compliance leads to other problems

- LOSA data revealed that, compared to crews who followed SOPs, crewmembers who intentionally deviated from procedures:
 - averaged making 3 times more errors
 - mismanaged more errors
 - found themselves in more undesired aircraft situations

Accident Prevention Strategies


Source: Boeing study of accident prevention strategies

Hull-loss Accidents over 10 Year Period





NTSB

A photograph of an airport scene. In the background, a tall, white air traffic control tower with a black top section stands against a clear blue sky. The foreground is a dry, grassy field. In the middle ground, there's a blue semi-transparent box containing yellow text. To the right, a small blue ground service vehicle is visible on the tarmac, and a portion of an airplane is seen in the distance.

“Gulfstream’s focus on meeting the G650’s planned certification date caused schedule-related pressure that was not adequately counterbalanced by robust organizational processes to prevent, identify, and correct the company’s key engineering oversight errors.”

Sanford, FL

July 2007





Declared Emergency

“Smoke in the cockpit.”

“Shutting off radios, elec.”



AIRCRAFT: N561N	DATE: 07-09-07	-ACTT	
MAINTENANCE WRITE-UP		-ACTL	
Entered By: ACT	Location: DAB	<input type="checkbox"/> Repaired <input type="checkbox"/> Replaced	
		<input type="checkbox"/> Released- Could Not Duplicate <input type="checkbox"/> Loaner Installed	
RADAR WENT BLANK DURING CRUISE FLIGHT. RECYCLED - NO RESPONSE... SMELL OF ELECTRICAL COMPONENTS <u>BURNING</u> TURNED OFF UNIT - PULLED RADAR CB. - SMELL WENT AWAY. - RADAR INOP		Corrective Action:	


**“SMELL OF ELECTRICAL
COMPONENTS BURNING”**

**“PULLED RADAR CB
– SMELL WENT AWAY.
RADAR INOP”**

MECHANIC: “We have a discrepancy with the airplane.”

PILOT: “I know about the radar, I don’t give a # about that, I’m taking the airplane.”

As recounted by mechanic. Source: Ops Group Factual Report. p. 24



“the actions and decisions by [the organization’s] corporate aviation division’s management and maintenance personnel to allow the accident airplane to be released for flight with a known and unresolved discrepancy, and the accident pilots’ decision to operate the airplane with that known discrepancy, a discrepancy that likely resulted in an in-flight fire.”

Akron, Ohio
November 2015





Aerial View of Destroyed Building



Probable Cause

- The flight crew's mismanagement of the approach and multiple deviations from company standard operating procedures, which placed the airplane in an unsafe situation and led to an unstabilized approach, a descent below minimum descent altitude without visual contact with the runway environment, and an aerodynamic stall.
- Contributing to the accident were Execuflight's casual attitude toward compliance with standards; its inadequate hiring, training, and operational oversight of the flight crew; the company's lack of a formal safety program; and the Federal Aviation Administration's insufficient oversight of the company's training program and flight operations.



Free Lesson

“Learn from the mistakes of others. You won’t live long enough to make them all yourself.”





National Transportation Safety Board